DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-2018 (Rev. 01/2004)

STATE OF WISCONSIN
SOS Desk (608) 266-9198
Completion of this form meets the requirements of the State / County contract specified under the Wisconsin Statutes. S. 46.031(2g).
P.L. 97-35; Federal Regulations: 42 CFR 441

HSRS LONG-TERM SUPPORT MODULE

MODULE TYPE A

1 Worker ID

REGISTRATION - Screen L1 N / U / I / E (Module Key:)

2a Last Name	2b First Name	2c Middle Name	2d Suffix	3 MA Number (10 digits) **OR** SSN (9 digits)	4 Client ID

5 Birthdate (mm/dd/yyyy)	6 Sex F / M	7a Hispanic / Latino Y = Yes N = No	7b Race (Circle up to 5) A = Asian B = Black or African American P = Native Hawaiian or Pacific Islander I = American Indian or Alaska Native W = White	8 Client Characteristics	9 Level of Care	10 Marital Status	11 Living Arrangement Prior / Current / People

12 Natural Support Source	13 Type of Movement / Prior Location (Circle 1) (Optional for COP assessment, plan, applicant register) N = Relocated from general nursing home F = Relocated from ICF / MR facility D = Diverted from entering any type of institution B = Relocated from brain injury rehab unit	14 Special Project Status	15 County of Fiscal Responsibility	16 Court Ordered Placement Y = Yes N = No	17 MA Waiver Financial Eligibility Type A = Categorically eligible B = Categorically financially eligible - special income limit C = Medically needy D = COP eligible	18 Indicator for Waiver Mandate (Optional for COP assessment, plan, applicant register) A = MA Waiver eligible B = Not MA Waiver eligible C = MA Waiver eligible but exempt

SERVICES - Screen L2 U/I/E (Module Key:)

19 Episode End Date	20 Closing Reason	CIP1, CLTS-W, BIW Only: 21 Slot Number	22 Start Date	23 End Date
		STATE USE ONLY	STATE USE ONLY	

Provider Number Required for SPCs:
102 Adult day care
202/01/02 Adult family home
506 CBRF
604 Supportive and service coordination (CIP1A, 1B, BIW, CLTS-W)
711 Residential care apt. complex

PGM No	24 SPC/Subprogram	25 Target Group	26 LTS Code	27 Funding Source	28 SPC Start Date	29 SPC End Date	30 Provider Number	31 SPC Review Date mm	yyyy

NOTE: Street address, city, state, zip code and county are required for CIP 1A, 1B, BIW and CLTS-W on the back of this form.

UNITS / COSTS - Screen L3 U / I **(Module Key:)**

PGM No	32 Units	33 Costs	34 Delivery Date mm yyyy
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	

NOTE: Street address, city, state, zip code and county are required for CIP 1A, 1B, BIW and CLTS-W.

OPTIONAL DATA - Screen 18 **(Module Key:)**

Street Address		City	State	Zip Code	County	Telephone ( )
Case Review Date	Diagnosis	Family ID	Local Data			**Shaded areas are optional.**